information systems can be forgiven if they are confused by a plethora of terms that seem designed to hinder comprehension. But this is part of our new world, and it behoves us to attempt to understand it.

Dr Read was until very recently a full time general practitioner. His original ambition was to develop a set of diagnostic codes for use in general practice. But they were perceived to have a much wider application and they received such acclaim that he was encouraged to forsake general practice to become director of the Centre for Coding and Classification, which is based in Leicestershire. The Read code can be mapped on to the older systems such as ICD 9 and OPC 4 but the momentum behind the new method is such that it may well supersede these altogether in due course. It provides a dictionary that can already summarise clinical information in considerable detail: moreover, its structure lends itself to continuing development.

Each Read code has at present up to five characters. The code is hierarchical from left to right with each character offering progressively more detail. The first character defines the broad class, the second character the sub class, and so on. Each of the five characters may be a digit 0 to 9 or a letter a to z or A to Z. The letters i and o are excluded to avoid confusion with the digits 0 and 1. This still leaves over 650 million possible codes within the five character framework. An example illustrates the possibilities.

Level	*Term*	*Read*	*ICD-9-CM*
1	Circulatory system disease	G	390–459
2	Ischaemic heart disease	G3	410–414
3	Acute myocardial infarction	G30	410
4	Other acute myocardial infarction	G30y	410·8
5	Acute papillary muscle infarction	G30y1	410·8

Dr Read pointed out that the code was designed primarily to be useful for recording and retrieving clinical information and not specifically for grouping patients according to resource utilisation.

The Read approach allows coding of occupation, history and symptoms, examination and signs, diagnostic and laboratory procedures, and so on—as well as a wide range of diagnoses. In theory, most of the medical record could be coded for ease of storage and retrieval, but the record itself will still be written in English by doctors. The reader will be relieved that we are not expected to face in the ward, catheter laboratory, operating theatre, or outpatient department a sheet composed of a long string of letters and numbers that have replaced ordinary language.

Thirty eight working groups are currently engaged in extending the Read codes. It seems clear that they will become a national standard. The Data Management Committee believe the British Cardiac Society should cooperate with the Centre for Coding and Classification to ensure that the Read classification and descriptive language benefit from the closest cooperation from the specialty. We hope that this objective can be achieved in association with others who have a legitimate interest. At some stage joint working groups may be needed to ratify proposals and to ensure that a wide consensus has been achieved.

We have more news of our plans to provide adequate identification cards for patients with valve replacements. The plan has now been approved by the Executive of the Cardiothoracic Surgeons of Great Britain and Ireland. The scheme will operate in cooperation with the valve registry kept by Professor Ken Taylor. A small committee has been set up with representation from cardiology as well as from cardiothoracic surgery, and cooperation is being sought from the valve manufacturers. We envisage that cards, probably similar to credit cards, will be given to every patient. These are likely to show the type and serial number of the valve, to identify the surgical centre, and to give the implantation date, as well as providing the usual demographic data. We hope this can be achieved without cost to the patient or additional expense for the centres.

Plans for the new registrar training programme are moving ahead slowly. Many of the regions have already adopted the lead given by the cardiologists and later by other specialties in making provision for three years' training at registrar level (we look forward to the abolition of the terms "registrar" and "senior registrar", because they are too closely associated with older concepts and thereby obscure the changes that must occur to meet modern needs). Manpower representatives of the major clinical specialties met, under the auspices of the Royal College of Physicians of London, with officers of three regional health authorities and discussed the way forward for the introduction of the new style posts, given the problems and constraints of the cuts in posts for career trainees imposed by the Joint Planning Advisory Committee. We found great goodwill, and we were encouraged to believe that the problems associated with the changes can be overcome fairly quickly. More meetings will be arranged and more news will be forthcoming soon.

Finally, a reminder that the closing *postmark* date for abstracts for the American College of Cardiology (12 April to 16 April 1992, Dallas) is Friday 6 September 1991.

DOUGLAS CHAMBERLAIN
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NOTICES

1992

The Annual Meeting of the **British Cardiac Society** will take place at the Harrogate International Centre on 26 to 29 May. The closing date for receipt of abstracts is 3 January 1992.

The Arizona Heart Institute will hold its **International Congress V: Strategies in Endovascular Interventions** on 12 to 16 February in Scottsdale, Arizona. The deadline for submission of abstracts is 1 October 1991: Erika Scott, International Congress V, 2632 N 20th Street, Phoenix, AZ 85006 (Tel: 602 266 2200).

The **12th International Symposium on Intensive Care and Emergency Medicine** will be held at the Brussels Congress Centre on 23 to 27 March: Professor J L Vincent, Department of Intensive Care, Erasme University Hospital, Route de Lennik 808, B-1070 Bruxelles, Belgium (Tel: 32 2 526 33 80; Fax 32 2 526 45 55).

The **41st Annual Scientific Session and Exposition** will be held in Dallas, Texas on 12 to 16 April. The deadline for submission of abstracts is 6 September 1991: American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20814–1699 (Tel: 800 253 4636–301 897 2693).